Vision Office Information Form

These blank forms may be copied as needed for additional offices and practitioners.

Please complete a Vision Office Information Form for each location associated with a **UNIQUE TAX IDENTIFICATION NUMBER**. If more than one location is associated with the **SAME TAX IDENTIFICATION NUMBER**, attach a separate sheet listing office location addresses. Each Vision Practitioner should complete a Vision Practitioner Application and sign the Affirmation and Release of Information section of the application. If there is more than one practitioner associated with the tax identification number, complete the Vision Practitioner Application for each practitioner.

Please check the appropriate box:

☐ This is a new Vision Provider office application

☐ I am changing contact information

☐ I am adding an office location with an existing contract and Tax ID number

☐ I am adding a vision practitioner

Mail or fax the following documents:

☐ Letter of Agreement/Contract

☐ Office Information Form

☐ Ophthalmologist/Optometrist application

☐ Ophthalmologist/Optometrist supporting documentation (listed on Vision Practitioner Application below)

Mail or fax the application and documentation to:

Network Development & Provider Data Maintenance Department
UPMC Vision *Advantage* PPO
112 Washington Place, 6th Floor
Pittsburgh, PA 15219

Fax: 412-454-8225

Contract Questions? Call 412-454-5264.
Credentialing Questions? Call 412-454-8535.

VISION PROVIDER OFFICE INFORMATION

Primary Office Name:			E-mail:	
Street Address:		Suite Number:	Phone:	
City:	State:	Zip:	County:	Fax:
Tax ID Number:		Payee Name:		
Credentialing Contact Person: Title:			E-mail:	

Legal Status: ☐ Corporate ☐ Individual ☐ Sole Proprietorship ☐ Partnership ☐ Non-Profit Organization

OFFICE DESCRIPTION

Languages spoken (other than English) by provider and/or staff:

Hours of Operation:

Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:

Office Provides: ☐ Vision Care Services Only ☐ Vision Product Only ☐ Both Service and Product

I certify all information given by me to the foregoing questions and statements to be true and correct and complete without omissions of any kind.

Signature	Name (please print)	Title	Date

Vision Practitioner Application

Application Instructions and Checklist

Please complete the following Vision Application using **black** or **blue** ink. Answer all questions completely. If more space is needed than provided on this application, attach additional sheets and reference the question being answered. Complete all date information as requested. Incomplete information will delay the credentialing process. Sign and date in the "Affirmation and Release of Information" section. Fax or mail the following documentation with your application.

SUPPORTING DOCUMENTATION:

- ☐ Copy of Board Certification
- ☐ Copy of State License, in all states in which you practice
- ☐ Copy of DEA Certificate, in all states in which you practice
- ☐ Copy of Curriculum Vitae or Resume
- ☐ Copy of W-9 Form
- ☐ Copy of Current Malpractice Policy Cover Page
- ☐ If you answered "Yes" to any of the questions in section 9 "Declarations," submit a full explanation on a separate sheet
- ☐ Completed and signed Letter of Agreement/Contract

Practitioner Rights

- You have the right to review information submitted in support of your application.
- You have the right to correct this information by initialing and dating the correction and re-signing and dating the application any time prior to review by the Credentials Committee.
- You have the right to receive the status of your application upon request.

1. PERSONAL INFORMATION

Last Name: Suffix:	First Name: M.I.:
Degree:	Gender: ☐ Male ☐ Female

2. TYPE OF AFFILIATION REQUESTED

Specialty: ☐ Ophthalmology ☐ Optometry

3. LICENSURE, DEA, AND IDENTIFICATION NUMBERS

Social Security Number: ☐☐☐-☐☐-☐☐☐☐	Individual NPI Number: ☐☐☐☐☐☐☐☐☐☐	Date of Birth – Required (MM/DD/YYYY) ☐☐-☐☐-☐☐☐☐

License Number: Pennsylvania:	Other State:
DEA Number: Pennsylvania:	Other State:

4. PROFESSIONAL LIABILITY CARRIER INFORMATION

Current Insurance Carrier:		Policy Number:	
Effective Date: Month: Year:	Expiration Date: Month: Year:	Occurrence:	Aggregate:

5. BOARD CERTIFICATION – REQUIRED FOR OPHTHALMOLOGISTS ONLY

☐ Certified ☐ Not Certified Certifying Board:

Are you pursuing Board Certification? ☐ Yes ☐ No Anticipated date of board exam: Month: Year:

6. EDUCATION/TRAINING

Medical/Optometry School:		Degree:	
City:	State:	From: Month: Year:	To: Month: Year:

Additional Training

Institution:		Department:	
Type of Training: ☐ Internship	☐ Residency	☐ Fellowship	
City:	State:	From: Month: Year:	To: Month: Year:

7. EMPLOYMENT HISTORY

List all relevant work history since completion of post-graduate training or provide a resume or curriculum vitae. There should be no gaps in the chronology larger than six (6) months. If any gaps are larger than six (6) months, please submit explanation. Employment history must include month **and** year.

Practice/Employer:	City:	State:	Zip Code:
Title/Position:	From: Month: Year :	To: Month:	Year :
Practice/Employer:	City:	State:	Zip Code:
Title/Position:	From: Month: Year :	To: Month:	Year :
Practice/Employer:	City:	State:	Zip Code:
Title/Position:	From: Month: Year :	To: Month:	Year :

8. CONFLICT OF INTEREST

Are you an owner of or an investor in a health care facility or health care entity? ☐ Yes ☐ No

If "Yes," Name of Organization: _____ Your relationship to the organization: _____

If "Yes," how do you inform patients of your interest? _____

9. DECLARATIONS

As you consider the questions, include all past and present issues.

Have you ever had any of the following denied, revoked, suspended, restricted, lost, limited, placed on probation, including, but not limited to, disciplinary action(s), or have you voluntarily relinquished any of the following in anticipation of any of these actions, or are any of these actions now pending?

1. License, in any State	☐ Yes	☐ No
2. DEA registration	☐ Yes	☐ No
3. Other professional registration/license	☐ Yes	☐ No
4. Academic appointment	☐ Yes	☐ No
5. Medical/Clinical/Hospital staff privileges	☐ Yes	☐ No
6. Prerogatives/rights on any medical staff	☐ Yes	☐ No
7. Other institutional affiliation status	☐ Yes	☐ No
8. Professional society membership	☐ Yes	☐ No
9. Professional liability insurance	☐ Yes	☐ No
10. Have you ever had disciplinary action taken against you in the military?	☐ Yes	☐ No
11. Have any complaints been filed against you with a professional association or vision/medical society?	☐ Yes	☐ No
12. Have you ever been advised that you should not perform your professional or vision/medical staff duties?	☐ Yes	☐ No
13. Have you used illegal drugs in the last ten years?	☐ Yes	☐ No
14. Have you ever been convicted of, or pleaded guilty to, a crime or felony, including a verdict of guilty following a plea of *nolo contendere*?	☐ Yes	☐ No
15. Have you been the subject of any Medicaid, Medicare, or other governmental or third party payer sanctions; or has your participation in these or any other government programs been denied?	☐ Yes	☐ No
16. Do you have a physical or mental impairment, including, but not limited to, use of any legal or illegal substance (including drugs or alcohol) that limits your ability to perform the essential duties of clinical practice, with or without accommodation? Describe the accommodation needed on a separate sheet of paper and attach to this application.	☐ Yes	☐ No
17. Within the last five (5) years based on year of incident, have you been a defendant to a malpractice suit(s) or arbitration proceeding(s), or any malpractice administrative hearing(s), if applicable in your state, which went to final disposition (judgment or settlement) and resulted in payment from you, or your carrier on your behalf, to any party?	☐ Yes	☐ No
18. Within the last five (5) years based on year of incident, have you been a defendant to a malpractice suit(s) or arbitration proceeding(s), which are presently pending against you or any malpractice administrative hearing(s), if applicable in your state?	☐ Yes	☐ No

- If you have "Yes" answers to any of the questions, provide full details on a separate sheet.
- Please respond to each question individually and in detail, including all past and present issues.

10. APPLICANT'S AFFIRMATION AND RELEASE OF INFORMATION

I acknowledge and agree that UPMC Vision *Advantage* PPO has a valid interest in obtaining and verifying information concerning my professional competence in determining whether to enter into an agreement with me for the provision of services to members and I wish to enter into such an agreement. Accordingly, intending to be legally bound:

1. I represent and warrant to UPMC Vision *Advantage* PPO that the information contained in the foregoing application is true and complete to the best of my knowledge and belief, and I agree to inform UPMC Vision *Advantage* PPO promptly if any material change in such information occurs, whether before or after my entering into an agreement with UPMC Vision *Advantage* PPO for the provision of medical services;

2. I authorize UPMC Vision *Advantage* PPO, and/or its credentials verification organization (CVO), to consult with hospital administrators, members of hospital staff, malpractice carriers, and other persons as applicable to obtain and verify information concerning my professional competence, ability to work with others, character, and moral and ethical qualifications, and I release UPMC Vision *Advantage* and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application;

3. I consent to the release by any source, person, or organization to UPMC Vision *Advantage* PPO of all information that reasonably may be relevant to an evaluation of my professional competency, character, and moral and ethical qualifications, including any information relating to any disciplinary action, suspension, or curtailment of privileges and hereby release any such person or organization providing such information from any and all liability for doing so;

4. I consent to the inspection by all representatives of UPMC Vision *Advantage* PPO of all documents that may be material to an evaluation of my qualifications and competence;

5. I pledge to maintain an ethical practice, to provide for the continuous care of my patients, and to refrain from delegating the responsibility for care of my patients to any person not qualified to undertake that responsibility;

6. I acknowledge that as an applicant for participation, I have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications for such participation and for resolving any doubts about such qualifications;

7. I acknowledge that any misstatements or omissions of any material fact from this application constitute cause for denial of participation or cause for summary dismissal from the UPMC Vision *Advantage* PPO Provider Network;

8. I attest that I currently maintain malpractice insurance at no less than the current state required minimum in which my practice(s) resides.

9. I certify that I am not currently engaging in illegal drug use.

10. I acknowledge that a photocopy of this permission will serve as the original.

11. I acknowledge that, by signing this application, UPMC Vision *Advantage* PPO has advised me of my right to review and correct information obtained in the credentials process that varies from the information which I submitted on my application and upon my request, to be informed of the status of my credentialing/recredentialing application.

12. I understand that if my application is rejected for reasons relating to my professional conduct or competence, UPMC Vision *Advantage* may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank and any other appropriate authority body.

13. I certify all information given by me to the foregoing questions and statements in this application to be true and correct and complete without omissions of any kind.

Signature	Name (please print)	Date

VA APP C20101019-15 (JT) 10/19/10 PDF